October 10, 2002

Re: Medical Dispute Resolution
MDR #: M2.02.1124.01
IRO Certificate No.: IRO 5055

Dear

In accordance with the requirement for TWCC to randomly assign cases to IROs, TWCC assigned your case to ___ for an independent review. ___ has performed an independent review of the medical records to determine medical necessity. In performing this review, ___ reviewed relevant medical records, any documents provided by the parties referenced above, and any documentation and written information submitted in support of the dispute.

The independent review was performed by a matched peer with the treating health care provider. A physician Board Certified in Neurology reviewed your case.

The physician reviewer **AGREES** with the determination of the insurance carrier. The reviewer is of the opinion that a repeat EMG and CT Myelogram are **NOT MEDICALLY NECESSARY**.

I am the Secretary and General Counsel of ___ and I certify that the reviewing physician in this case has certified to our organization that there are no known conflicts of interest that exist between him and any of the treating physicians or other health care providers or any of the physicians or other health care providers who reviewed this case for determination prior to referral to the Independent Review Organization.

We are forwarding herewith a copy of the referenced Medical Case Review with reviewer's name redacted. We are simultaneously forwarding copies to the patient, the payor, and the Texas Workers' Compensation Commission. This decision by ___ is deemed to be a Commission decision and order.

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of this decision and has a right to request a hearing.

If disputing a spinal surgery prospective decision a request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings within ten (10) days of your receipt of this decision (28 Tex. Admin. Code 142.5©).

If disputing other prospective medical necessity (preauthorization) decisions a request for a hearing must be in writing and it must be received by the TWCC Chief

Clerk of Proceedings within twenty (20) days of your receipt of this decision (28 Tex. Admin. Code 148.3).

This Decision is deemed received by you five (5) days after it was mailed (28 Tex. Admin. Code 102.4(h) or 102.5 (d)). A request for a hearing should be sent to:

Chief Clerk of Proceedings
Texas Workers' Compensation Commission
P.O. Box 40669
Austin, TX 78704-0012

A copy of this decision should be attached to the request. The party appealing the decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute.

I hereby verify that a copy of this Independent Review Organization (IRO) Decision was sent to the carrier, the requestor and claimant via facsimile or U.S. Postal Service from the office of the IRO on October 10, 2002.

Sincerely,

MEDICAL CASE REVIEW

This is for ___. I have reviewed the medical information forwarded to me concerning MDR #M2-02-1124-01, in the area of Neurology. The following documents were presented and reviewed:

A. MEDICAL INFORMATION REVIEWED:

1. Patient's past medical history and medical records from her workup starting in 1997, including work from ___, her EMG, and two CAT scans done.
2. Functional Capacity Evaluation.
3. Notes before and after her first surgery.

B. BRIEF CLINICAL HISTORY:

The patient initially had an injury in ___, was evaluated at that time, and underwent a lumbar fusion in 1996. She was re-admitted in 1997 with exacerbation of her pain. CT myelogram showed some fibrosis and arachnoiditis, but no surgical disease.

She has continued to be followed by ___. An EMG done in July 1997 was basically normal. A CAT scan was done 6/04/01 and subsequently again on 8/02/02. These did not show any evidence for surgical disease.

The patient, throughout the course, has continued to show back pain, variable leg pain and variable weakness, but no objective neurological findings and no specific pattern of a definite radiculopathy. She has also shown consistent give-way weakness.

C. DISPUTED SERVICES:

Repeat EMG and CT myelogram.

D. DECISION:

I AGREE WITH THE DETERMINATION OF THE INSURANCE CARRIER IN THIS CASE.

E. RATIONALE OR BASIS FOR DECISION:

There is no really good indication for a CT myelogram given her clinical pattern and a normal CT of the lumbar spine on 8/02/02. The EMG is also not indicated, in that she has no specific deficit, no findings for peripheral neuropathy, no findings for definite weakness, and I do not think it will contribute to the need for surgical intervention, in that the patient does not really have any specific nerve root pattern.

F. DISCLAIMER:

The opinions rendered in this case are the opinions of this evaluator. This medical evaluation has been conducted on the basis of the documentation as provided to me with the assumption that the material is true, complete and correct. If more information becomes available at a later date, then additional service, reports or consideration may be requested. Such information may or may not change the opinions rendered in this evaluation. My opinion is based on the clinical assessment from the documentation provided.

I certify that I have no past or present relationship with the patient and no significant past or present relationship with the attending physician. I further certify that there is no professional, familial, financial, or other affiliation, relationship, or interest with the developer or manufacturer of the principal drug, device, procedure, or other treatment being recommended for the patient whose treatment is the subject of this review. Any affiliation that I may have with this insurance carrier, or as a participating provider in this insurance carrier's network, at no time constitutes more than 10% of my gross annual income.

Date: 9 October 2002